



# Community Benefit of Improving Population Health Through Community Health Assessment at Essentia Health

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# Community Health Assessment

- Essentia Health must conduct a Community Health Assessment for IRS 990 reporting.
  - While hospitals are required to do this in order to maintain their non-profit status as a health system:
    - We have chosen to coordinate our Community Health Assessment efforts across Essentia Health

# Coordination cont'd

- By choosing to coordinate our efforts:
  - We are making the opportunity to align Community Health Assessment efforts with Essentia Health strategies
  - We enhance our ability to marshal our resources to address multiple Essentia Health goals that have a population health component such as ACO and PCMH national accreditation AND IRS Community Benefits reporting all of which requires engaging community members such as Essentia patients

# Standardization

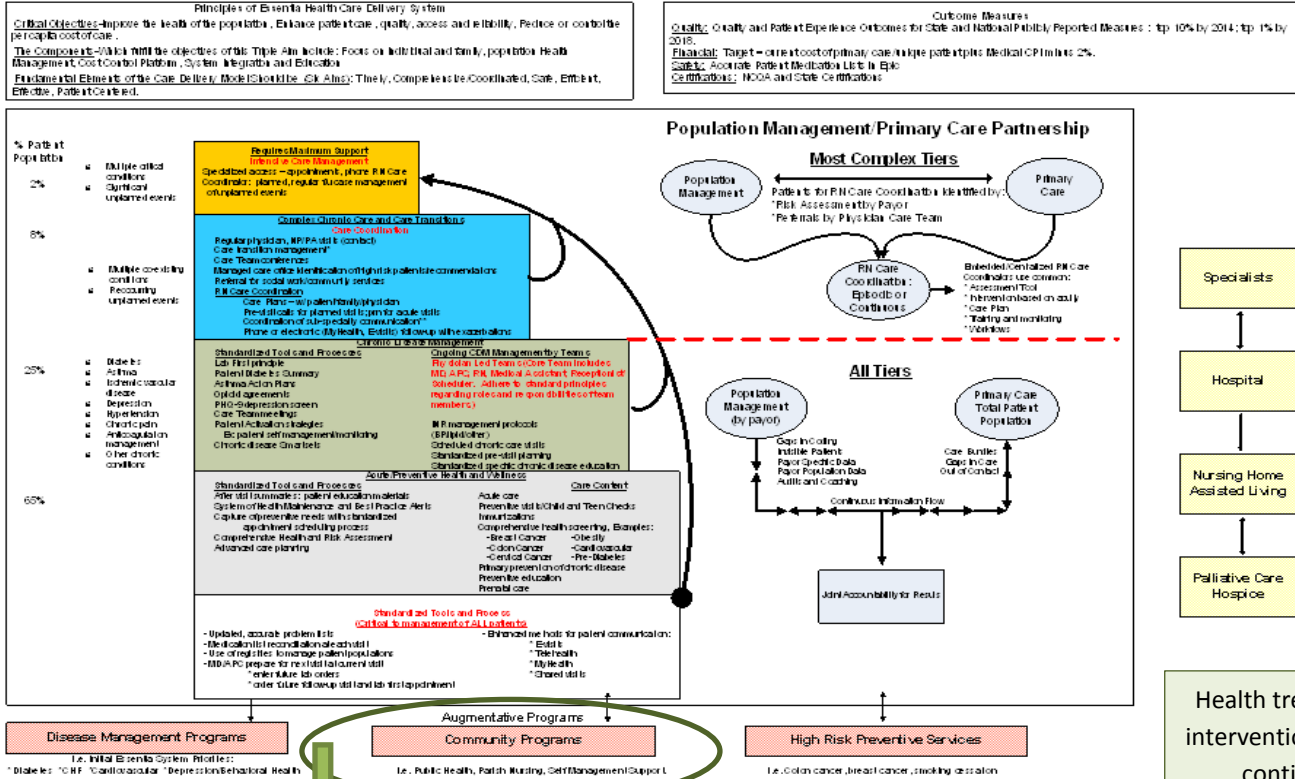
- With a coordinated approach to Community Health Assessment we are choosing to:
  - Standardize the process across all of our regions, hospitals, and communities
  - Methodically (process and outcome) evaluate health interventions developed in response to the Community Health Assessment

# Essentia Health Population



## Essentia Primary Care Delivery Model

Standard Tools, Processes, and Staffing Model Across Essentia



### VALUE

- An engaged community who own their health
- Targeted reduction in identified health disparities
- Community Health Interventions tied to EH vision, mission, and strategic planning

Review of analyzed health assessment data with patient partners through knowledgeable group discussion facilitation

Prioritization of health needs by patient partners

Sharing of priorities with broader community entities (e.g. local and State public health, Essentia primary care, agency on aging, etc.)

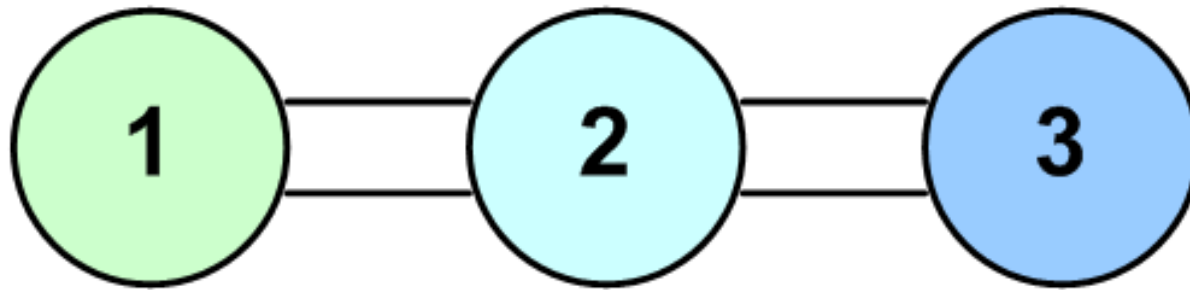
Consensus on health-related interventions (one developed annually per community that has clear outcomes and a 3-year time frame)

# *The Triple Aim*

- The health care system in the United States is broken and the triple aim has been a galvanizing force for drawing attention to this and for focusing attention on the generalized approaches needed to fix the U.S. health care system.

# *Population Health is integral to the triple aim*

## The Triple Aim



Improve the *health* of the population.

Improve the *experience* of care.

Improve *affordability* by reducing the per capita costs of health care.



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# *Accountable Care Organizations (ACO), Patient Centered Primary Care (PCMH), and Community Benefit*

- Accountable Care Organizations have been conceptualized as an important avenue for achieving the triple aim.
- PCMHs are at the heart of ACOs
  - PCMHs have shown to lower costs while improving health care outcomes
- Community Benefit, an IRS initiative, was conceptualized to help make the distinction between profit and non-profit hospitals
  - Community Health Assessments to establish areas for population health improvement are required



***This Matters Because** By 2013 ALL Non-Profit Hospitals in the U.S. Will Be Required By Law to:*

- Produce a Community Health Assessment for its *population* in order to maintain its non-profit status.
- There are at the very least two dire consequences to not doing this:
  - 1) the hospital may lose its non-profit status and therefore be subject to pay income tax.
  - 2) the IRS will levy a \$50,000 penalty for each hospital currently defined as a non-profit if it fails to submit a CHNA plan on time (30 June 2013)

# *The Interface of ACOs, PCMH, and Community Benefit: Population Health*



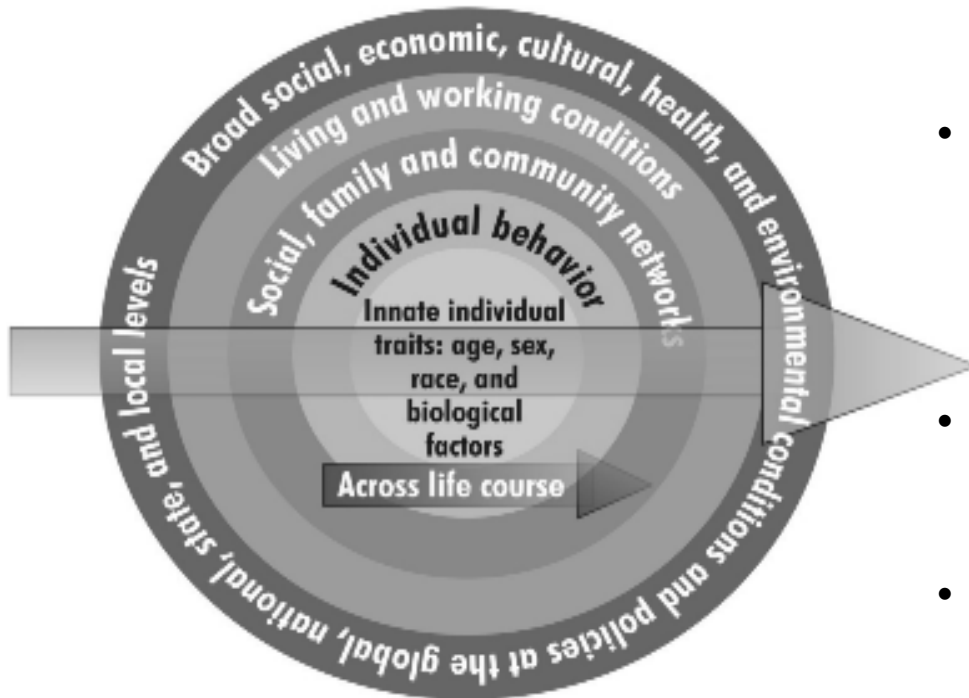
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# *Population health. . .*

- is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.
  - Improving population health, is essential for quality of life, and is the single most effective way to **reduce** health care costs.

# DHHS/CDC Population Health Model



- CDC has proposed this model for explaining the dynamics of population health .
- In many ways this model is the underpinning for the evolving leading health indicators CDC has developed for measuring and improving the health of the nation.
- Measuring population health requires ongoing community health assessment.
- Improving health requires developing and implementing meaningful community-based health interventions.



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# What is community health assessment?

- Community health assessment is a process involving the identification of problems, setting priorities, developing action plans, measuring progress, evaluating whether or not the actions have been/are effective, modifying the actions if necessary, and then re-evaluating the community's problems and priorities.

# A Social Justice Component to Community Health Assessment

- Assessing the health of the community is an ongoing activity and is often grounded in a concern with social justice that recognizes that:

*ALL LIVES HAVE EQUAL VALUE*

- and that:

*EVERYONE DESERVES TO LIVE A HEALTHY LIFE*

- The social justice component of community health assessment introduces health disparities as an important aspect of the health-focused assessment process.

# Health Disparities and Community Health Assessment

- In general, health disparities refer to differences between groups of people that impact how frequently a disease affects a group, how many people get sick, or how often the disease causes death.
  - Many different populations are affected by disparities. These may include:
    - Racial and/or ethnic minorities
    - Residents of rural areas
    - People of lower socio-economic status
    - Populations with health service deficits



# Essentia and Community Health Assessment

- Essentia Health has the opportunity to develop a community health assessment strategy that encompasses social justice concerns and a health disparities focus in order to develop community-based interventions to improve the health of the people in the communities and states where we work.
  - Assessing the health of communities always begins with the analysis of health-related data.
  - These data may come from a wide variety of sources including: population-based surveys, Vital Statistics or Health System Data Warehouses.



# IOM Community Health Improvement Process (CHIP)

*Improving Health in the Community*, IOM, 1997

- The community's health depends on the interaction of many factors, entities, organizations, and interests
- Community health is a shared responsibility
  - Community health assessment is inherently a community engagement process
- Specific entities in the community must be accountable for the actions that they can take to improve community health
  - Entity-specific performance measures must be developed and monitored

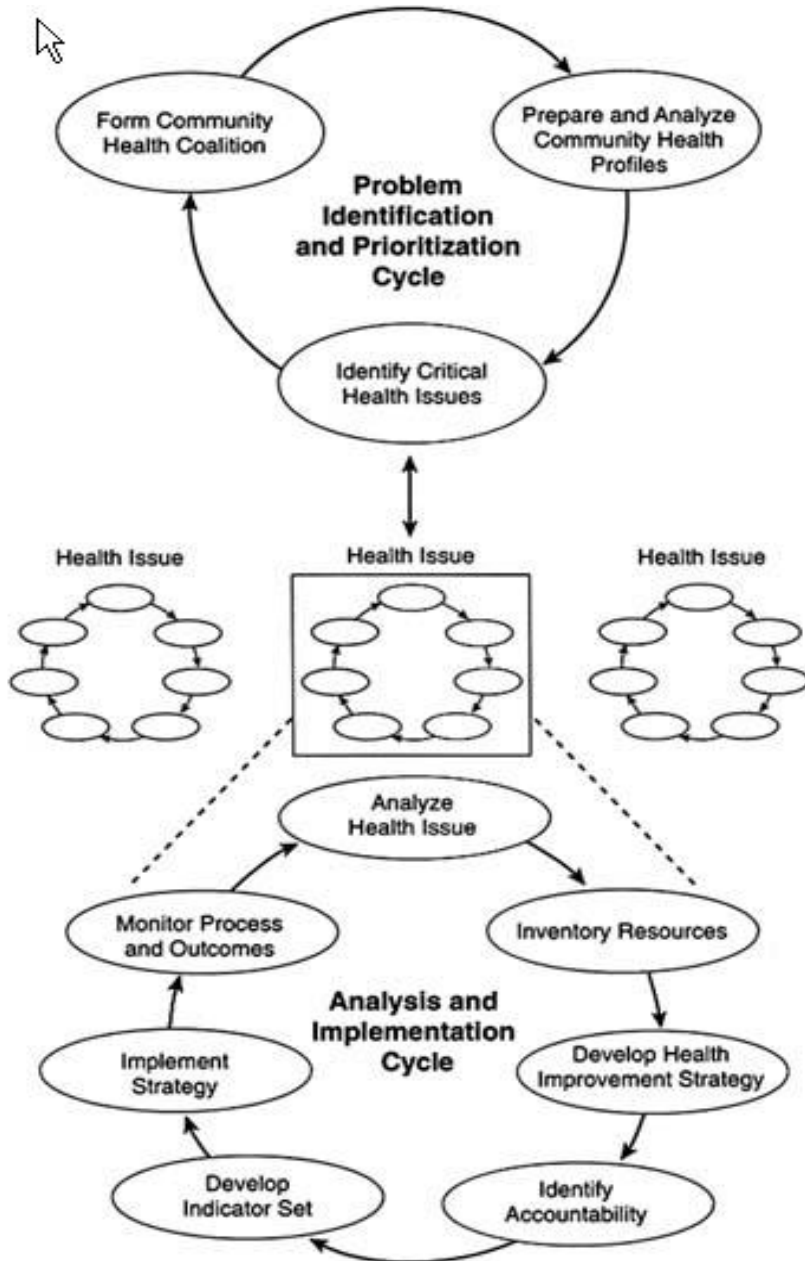
# Performance Measurement

- **Steps for developing measures**
  1. Clarify the purpose of measurement
  2. Identify the concepts to be measured
  3. Identify specific indicators of these concepts
  4. Assess validity, reliability, practicality, and utility

# Concepts vs. indicators

CONCEPT	INDICATOR or MEASURE
Mortality	Disease specific mortality rate
Presence of disease	Disease prevalence
Health risks	Risk factor prevalence
Costs	Treatment costs per patient
Quality	Patient satisfaction ratings
Access	Percent of population with health insurance

# The Community Health Assessment Process



In this model, adapted from the Institute of Medicine, the set of health-related indicators for a community health profile might include measures of:

- Socio-demographic characteristics (e.g., educational attainment, annual household income, age distribution)
- Health risk factors (e.g., immunization coverage, adult smoking rate, and obesity prevalence)
- Health services indicators (e.g., lack of health insurance, deferring medical care because of cost)
- Health status variables (e.g., diabetes by race/ethnicity, smoking prevalence by SES, or asthma prevalence by HSD)
- Functional status, such as the proportion of adults defining their health as good to excellent.

# *Some of the National Leading Health Indicators To Get Essentia Started*

- Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.
- Reduce the proportion of persons in the population with hypertension.
- Reduce the proportion of persons who experience major depressive episodes .
- Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
- Reduce tobacco use by adults.



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# Population Demographics for States Where Essentia Has a Presence

Measures		2009 BRFSS Data (Crude Prevalence)			
		Idaho	Minnesota	North Dakota	Wisconsin
Sex	Male	50.0	49.4	49.9	49.3
	Female	50.0	50.6	50.1	50.7
Age Ranges	18-34 Years	32.8	30.1	32.9	29.5
	35-64 Years	50.8	53.3	47.8	52.8
	>=65 Years	16.5	16.6	19.2	17.7
Annual Household Income	<\$35,000	40.7	26.0	33.3	37.9
	>=\$35,000	59.3	74.0	66.7	62.1
Educational Attainment	<High School	9.8	4.1	8.4	6.1
	Completed High School	60.4	54.5	59.9	63.8
	College Graduate	29.8	41.4	31.7	30.1
Marital Status	Married Or Living With Partner	70.1	68.2	66.8	66.2
	Unmarried And Not Living With A Partner	29.9	31.8	33.2	33.8
Race/Ethnicity	Caucasian	88.4	91.5	89.8	89.0
	African American	.2	2.5	.6	3.0
	Hispanic	6.7	1.9	2.0	3.1
	Other/Multiracial	4.7	4.1	7.6	4.9
At Least 1 Child In Household		45.9	43.1	39.7	39.6
Socioeconomic Status*	Low SES	37.1	22.1	29.1	35.5
	Middle SES	49.5	52.3	55.6	49.3
	High SES	13.4	25.6	15.3	15.3
At Least 1 Health Service Deficit**		56.8	42.8	50.4	44.2
Population In State Rural		36.3	29.2	61.0	30.6

\*SES is a composite or computed variable comprised of two categorical variables: education and income.

\*\*Health service deficits, entailed a lack of health insurance, not having a healthcare provider, deferring medical care because of cost and having had no routine medical exam



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# *Population Risk Factors and Disease Status for States Where Essentia Has a Presence*

Measure		2009 BRFSS (Crude Prevalence)			
		Idaho	Minnesota	North Dakota	Wisconsin
Overweight or Obese	BMI 25-<30	36.2	37.9	37.8	36.4
	BMI >=30	25.1	25.4	28.4	29.2
Physically Inactive		42.5	47.3	47.7	47.2
Diabetes		8.0	6.4	7.5	8.2
Hypertension		26.1	22.3	27.1	28.1
Hyperlipidemia		37.2	33.9	34.8	35.8
Asthma		12.7	9.6	12.0	13.7
Arthritis		23.7	20.9	27.4	25.2

# *Examination of a Specific Health Issue: The Case of Smoking*

**2009 BRFSS Data (crude prevalence)**

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke
<b>Overall State Prevalence</b>		16.3	83.7	16.8	83.2	18.6	81.4	18.8	81.2
<b>Race/Ethnicity Prevalence</b>	<b>Caucasian</b>	16.1	83.9	16.1	83.9	16.1	83.9	17.8	82.2
	<b>Non-Caucasian</b>	17.5	82.5	23.6	76.4	40.6	59.4	26.6	73.4
<b>Geographic Locale Prevalence</b>	<b>Non-Rural</b>	15.1	84.9	16.5	83.5	13.3	86.7	18.5	81.5
	<b>Rural</b>	18.4	81.6	17.4	82.6	22.0	78.0	19.4	80.6
<b>Socioeconomic Prevalence</b>	<b>Low</b>	27.7	72.3	31.8	68.2	30.8	69.2	29.6	70.4
	<b>Middle</b>	11.2	88.8	15.7	84.3	16.6	83.4	16.3	83.7
	<b>High</b>	4.3	95.7	6.2	93.8	7.7	92.3	4.8	95.2
<b>Service Deficit Prevalence</b>	<b>No HSD</b>	10.6	89.4	12.7	87.3	13.5	86.5	13.4	86.6
	<b>At Least 1 HSD</b>	20.3	79.7	22.4	77.6	23.6	76.4	25.6	74.4



# EIRH Will Lead a CHA Process That Will:

- Facilitate standardizing an assessment of the health of our populations and the subsequent development of meaningful health interventions that are aligned to Essentia's strategies.
  - *Patients and families will be included* in the health assessment process and will inform the prioritization of health needs and interventions to address these
  - Interventions *coordinated* with need will *support patient* communities to reduce health risk factors

# *Deliverables*

- 1) A standardized CHA plan for all of Essentia Health's Hospitals. This plan will include:
  - a) clear definitions of the population(s) or communities being served
  - b) delineation of the process and methods used to conduct the CHA including input from patients/community members, relevant community agencies, primary care clinics and local and state health departments



# *Deliverables, cont'd*

- c) community prioritization of health needs based on a shared analysis of health related data (e.g., CDC's Behavioral Risk Factor Surveillance System Data)
  - each community will identify a new priority annually
- d) developed intervention for each community's initially selected health priority as part of the implementation strategy to address prioritized health needs
  - Interventions will have an initial life cycle of three years
- e) evaluation plan for each intervention
  - That will have a three year cycle
- f) a description of existing facilities and resources by community